	Fields		Provider Type		Field		Description/Valid Codes/Standard	OIC Edit
	No.	Name	1	2,3,4&9	Type	Width		
Control #	1	RecordControl	x	x	Text	1	Insert the letter "A" into this field. This indicates the beginning of the record.	TR
Carrier Information	2	Network	x	x	Text	90	Enter the specific name used by the carrier to identify the network. Pattern is **NAIC#_NETWORK,** i.e., **12345_PPO**	TR
	3	ProgramType	x	x	Num	1	Enter the following program types, HO = 1, BH = 2, PEBB = 4, CHIP= 8 for each practitioner, hospital, or pharmacy that participates in each program. For providers not participating in the above government programs, leave this field blank.	NR
	4	HealthCarrier	x	x	Text	60	Enter the name of the carrier as it appears on the Certificate of Registration.	TR
	5	NAIC	x	x	Text	5	Enter the five digit NAIC (National Association of Insurance Commissioners) code assigned to the carrier.	TR
	6	CaEmail	x	x	Text	60	Enter the E-mail address of the person who submits this provider network data. (Confirmation of processing requires a valid e-mail address)	TR
Provider Information	7	PNPI	x	x	Text	10	Enter the Provider's National Provider Identifier (NPI). If these are not available, please contact the OIC for approval of an alternate identifier.	TR
	8	LicensePrimary	x	a	Text	10	Enter the professional license number in the format issued by the State of Washington, Oregon, or Idaho. See the attached table for format requirements.	TR
	9	LicenseStatePrimary	x	a	Text	2	Enter the state issuing the professional license. Use only the two character abbreviations, WA, OR, or ID.	TR
	10	InternalProviderID	x	a	Text	15	Enter the carrier's internal identification provider number. Required for PEBB PCPs using ProviderClinicCode (used for enrollment purposes). For providers not participating in the HO, BH, or PEBB government programs, leave this field blank.	Optional
	11	ProfDegree	x	a	Text	10	Enter the practitioner's professional title as listed on their license (e.g. MD, DO, ARNP, PA, LM, CNM) May be multiple if active.	TR
	12	LastName	x	a	Text	25	Enter the provider's full legal last name.	TR
	13	FirstName	x	a	Text	25	Enter the provider's full legal first name.	TR
	14	MiddleName	x	a	Text	25	Enter the provider's middle initial. Leave field blank if provider does not have a middle initial.	Optional
	15	Language	a	a	Text	50	If the practitioner speaks other languages than English, enter the Language(s) abbreviations listed on the attached table. If the provider does not speak an additional language, leave this field blank.	Optional

	Fields No.	Fields Name	Provider Type 1	Provider Type 2,3,4&9	Field Type	Field Width	Description/Valid Codes/Standard	OIC Edit
Provider Contract Information	16	SpecialtyPrimary	x	a	Text	50	Enter the approved abbreviation of the provider's specialty from the attached table.	TR
	17	SpecialtySecondary	x	a	Text	50	Enter the approved abbreviation of the provider's specialty from the attached table.	Optional
	18	ProvidesObstetricCare	x	a	Text	1	Enter "Y" if the practitioner offers obstetric services, including birthing. If no, enter "N".	TR
	19	ProvidesPediatricCare	x	a	Text	1	Enter "Y" if the practitioner offers pediatric services. If no, enter "N".	Optional
	20	PCPSpecialistBoth	x		Text	1	Enter P = Primary Care Provider, S = Specialist, B = Both.	Optional
	21	Limits	x	a	Text	50	Enter the practice limitations the provider places on his/her services (e.g., age 0-19, treats only adults, open 2 days a week). If no limits, leave field blank. For providers not participating in government programs, leave this field blank.	NR
	22	ProviderType	x	x	Num	1	Enter the correct provider type: 1=Practitioner 2=Hospital 3=Pharmacy 4=Clinic 9=Other. Cannot be blank.	TR
	23	Start	x	x	Date	10	Enter the HO, BH, or PEBB provider contract effective date. Must be in the required format: MM/DD/YYYY. This date may be in the future based on the contract effective date. For providers not participating in the above government programs, leave this field blank.	NR
	24	End	a	a	Date	10	Enter the HO, BH, or PEBB provider termination date, if known. Must be in the required format: MM/DD/YYY. For providers not participating in the above government programs, leave this field blank.	NR
	25	Website	x	x	Text	1	Enter "N" for No if this record cannot be published on the IPND web provider directory. If provider is not contracted with the Basic Health Plan, Healthy Options or the Public Employees Benefits Board, leave the field blank.	NR
Business Information	26	BNPI	x	x	Text	10	Enter the Provider's Employer National Provider Identifier (NPI). If these are not available, please contact the OIC for approval of an alternate identifier.	TR
	27	BusinessName	x	x	Text	65	Enter the name of Clinic, Office, Hospital or Pharmacy, as listed on its business license.	TR
	28	StreetAddress	x	x	Text	72	Enter the address of the physical location of the Clinic, Office, Hospital or Pharmacy. May not contain Post Office Box numbers or separate billing address. No suite numbers permitted. Please use the accepted US Post Office format (See attached). Please note that this field has been lengthened and StreetAddress2 omitted.	TR
	29	City	x	x	Text	25	Enter the full name of the city in which the business is physically located. Abbreviations will not be accepted.	TR
	30	State	x	x	Text	2	Enter the state the Clinic, Office, Hospital or Pharmacy is physically located. Use only the abbreviations, WA, OR ID.	TR
	31	Zip	x	x	Num	10	Enter the postal ZIP code in which the Clinic, Office, Hospital or Pharmacy is located in the required format: #####.	TR
	32	County	x	x	Text	15	Enter the full name in capital letters of the County in which the Clinic, Office, Hospital or Pharmacy is physically located.	TR
	33	DayPhone	x	x	Num	23	Enter the daytime business telephone number in the required format: (nnn) nnn-nnnn ext. nnnnn. (Telephone extensions are optional)	Length Only